



**Pali Women's
HEALTH CENTER**

642 Ulukahiki St. #305
Kailua, HI 96734

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

With this consent, the doctor and her staff may use and disclose protected health information (PHI), about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the doctor and her staff may call my home or other designated location and leave a message, on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the doctor and her staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the doctor and her staff may speak to and release my PHI to the following spouse, family member, relative, friend or parties listed below: (if you do not want your Health information shared with anyone please leave blank)

<u>Name</u>	<u>Relationship</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This consent covers the period of time from my first visit until I revoke my consent in writing. I release the doctor and staff from all legal responsibility that may arise from this authorization.

By signing this form, I am consenting to the doctor and her staff's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

Print Name of Legal Guardian

I have read the Notice of the Uses and Disclosures of Protected Health information. I was informed that I might also obtain a printed copy of the notice from the receptionist. I hereby acknowledge that I have viewed a copy of the notice.

Signature

Date